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IN THE
SUPREME COURT OF THE UNITED STATES

RUSH PRUDENTIAL HMO, INC.,

Petitioner,

v.

DEBRA C. MORAN AND STATE OF ILLINOIS,

Respondents.

On Writ of Certiorari To The United States Court of Appeals For the Seventh Circuit

BRIEF *AMICI CURIAE* OF AARP, NATIONAL EMPLOYMENT LAWYERS ASSOCIATION AND NATIONAL PARTNERSHIP FOR WOMEN & FAMILIES IN SUPPORT OF RESPONDENTS

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BRIEF *AMICI CURIAE* OF AARP, NATIONAL EMPLOYMENT LAWYERS ASSOCIATION AND NATIONAL PARTNERSHIP FOR WOMEN & FAMILIES IN SUPPORT OF RESPONDENTS

INTERESTS OF *AMICI CURIAE*[1/]

AARP is a nonprofit membership organization of more than 35 million persons, age 50 or older, working or retired, dedicated to addressing the needs and interests of older

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[1/] No counsel for any party authored any portion of this brief. No persons other than *amici curiae*, their members, or their counsel have made a monetary contribution to the preparation and submission of this brief. The written consents of the parties have been filed with the Clerk of the Court pursuant to Supreme Court Rule 37.3.

Americans. AARP seeks through education, advocacy and service to enhance the quality of life for all by promoting independence, dignity, and purpose. In its efforts to promote independence, AARP works to foster the health and economic security of individuals as they age by attempting to ensure the availability of quality and economical health coverage. As the country's largest membership organization, AARP has a long history of advocating for access to affordable health care and for controlling its costs without compromising quality. As additional means to foster the economic security of older individuals, AARP seeks to increase the availability, security, equity, and adequacy of public and private pension, health, disability, and other employee benefits.

The National Employment Lawyers Association (NELA) is a voluntary organization, founded in 1985, of more than 3,000 attorneys who specialize in representing individuals in controversies arising out of the workplace. It is the country's only professional membership organization comprised of lawyers who primarily represent employees in cases involving employment discrimination, employee benefits, wrongful discharge, and other employment-related matters. NELA has devoted itself to supporting precedent-setting litigation affecting the rights of individuals in the workplace.[2/]

The National Partnership for Women & Families is a national non-profit organization working to improve the lives of women and families through public advocacy, public education, and private partnerships. Founded in 1971 as the

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[2/] As part of their advocacy efforts to ensure, to the greatest extent possible, that participants and beneficiaries receive the benefits of ERISA's protections, AARP and NELA have participated as *amicus curiae*, both jointly and singly, in numerous cases involving ERISA's pre-emption clause, including *Egelhoff v. Egelhoff*, 532 U.S. 141, 121 S. Ct. 1322 (2001); *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358 (1999); *Boggs v. Boggs*, 520 U.S. 833 (1997); *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806 (1997); and *California Div. of Labor Stds. Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316 (1997).

Women's Legal Defense Fund, the National Partnership promotes equal opportunity for women, quality health care, and policies that help women and men meet both work and family responsibilities. The National Partnership has a longstanding history of defending the interests of women in the workplace and working to ensure that women have access to the benefits they need to support themselves and their families. The National Partnership firmly believes that strong and enforceable patient protections are an essential component of quality health care. As a result, the National Partnership has been a leading voice in promoting and defending meaningful patient protections for individuals in employer-sponsored health plans and public health programs.

Participants and beneficiaries in private, employer-sponsored employee benefit plans rely on the Employee Retirement Income Security Act (ERISA) to protect their rights under those plans. 29 U.S.C. § 1001 *et seq.* Contrary to ERISA's purpose, however, a statute that was designed to safeguard employee benefits has too frequently been used to deprive employees of rights and protections they previously enjoyed under state law. More recently, there have been attempts to use ERISA to undercut state attempts to regulate health care,[3/] even though the Court has recognized that such regulation is an area of traditional state concern. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, (*Travelers*) 514 U.S. 645, 654-55 (1995). Such court decisions bear directly on the ability of working Americans represented by AARP, NELA and the National Partnership to vindicate their claims for benefits as well as states' attempt to provide better consumer protections for their

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[3/] *Compare, e.g., Washington Physicians Serv. Ass'n v. Gregoire*, 147 F.3d 1039 (9th Cir. 1998), *cert. denied*, 525 U.S. 1141 (1999), *with Prudential Ins. Co. of Am. v. National Park Med. Ctr., Inc.*, 154 F.3d 812 (8th Cir. 1998). *See generally* Karen A. Jordan, *The Shifting Pre-emption Paradigm: Conceptual and Interpretive Issues*, 51 VAND. L. REV. 1149 (1998).

citizens.[4/] Thirty-nine states and the District of Columbia have implemented some form of independent review of health plan coverage decisions.[5/] In light of the significance of the issues presented by this case, AARP, NELA and the National Partnership for Women & Families respectfully submit this brief *amici curiae*.

SUMMARY OF ARGUMENT

ERISA's pre-emption clause states that it expressly pre-empts state laws that relate to an employee benefit plan and are not saved as a state law that regulates the business of insurance. ERISA §§ 514(a) & (b)(2). In its recent search to better define the parameters of the "relates to" portion of ERISA's pre-emption clause, the Court has often turned to traditional pre-emption concepts to help it. *Travelers*, 514 U.S. at 654-55; *California Division of Labor Standards Enforcement v. Dillingham Construction, N.A., Inc.*, 519 U.S. 316 (1997). Accordingly, the Court has adopted the presumption that the historic police powers of the States are not to be superseded by federal law unless Congress' intent to do so is clear. *Travelers*, 514 U.S. at 655, quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947). It has also recognized that the purpose of the Congress is the ultimate touchstone of pre-emption analysis. *Cipollone v. Liggett Group, Inc.*, 505 U.S. 504, 516 (1992). The Court has maintained Congress intended to pre-empt only state laws

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4/ Approximately two-thirds of Americans under the age of 65 are eligible for health benefits through employment-based health plans. *See* Paul Fronstin, Employee Benefit Research Inst., *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2000 Current Population Survey*, EBRI ISSUE BRIEF NO. 228 at 7 (Dec. 2000). In 1999, slightly more than one-quarter of retirees reported current coverage an employer-sponsored health plan. EBRI HEALTH BENEFITS DATABOOK at 68, tbl. 6.1 (1999).

5/ American Association of Health Plans, INDEPENDENT MEDICAL REVIEW OF HEALTH PLAN COVERAGE DECISIONS: EMPOWERING CONSUMERS WITH SOLUTIONS (April 2001).

which refer to or have a significant connection with an ERISA plan. *Dillingham*, 519 U.S. at 332.

Here the state of Illinois is regulating in an area of traditional state concern – health care, thereby raising the presumption against pre-emption which Petitioner has not overcome. The Illinois HMO Act neither refers to nor has a connection with an ERISA plan and hence does not relate to an ERISA plan for three reasons. First, the state law only regulates HMOs as service providers not as ERISA plans. *Washington Physicians Service Ass'n v. Gregoire*, 147 F.3d 1039, 1044-45 (9th Cir. 1998), *cert. denied*, 525 U.S. 1141 (1999); *see generally Dillingham*, 519 U.S. at 325-28. Second, the state law has no reference to an ERISA plan because although an ERISA plan could choose to use an HMO as a service provider there is nothing in the state law requiring the plan to do so. *Dillingham*, 519 U.S. at 325, 328. Third, the Illinois HMO Act also has no connection with an ERISA plan because it does not mandate employee benefit structures, and it does not bind employers or administrators to particular choices. Nor does it preclude uniform administration practices, provide alternative enforcement mechanisms or regulate a principal ERISA relationship. *Travelers*, 514 U.S. at 657-60; *Blue Cross of California v. Anesthesia Care Associates Medical Group, Inc.*, 187 F.3d 1045 (9th Cir. 1999); *Custer v. Sweeney*, 89 F.3d 1156 (4th Cir. 1996). The Illinois HMO Act does not mandate the distribution, payment or receipt of benefits. Instead it is limited to a process for determining appropriate medical treatment, an area of traditional state concern, which this Court has recently recognized is not pre-empted. *Pegram v. Herdrich*, 530 U.S. 211 (2000). Moreover, by its plain language, this Act provides the insured with no right to initiate the process, no right to appeal the plan's denial of the benefit, and no right to obtain benefits from the plan. This is not an alternative enforcement mechanism. Indeed, all this state law does is to provide a mechanism for handling disputes between physicians and HMOs, clearly not a regulation of a principal ERISA relationship. *Blue Cross*, 187 F.3d 1045, 1054; *Custer*, 89 F.3d 1156, 1167.

However, assuming for the sake of argument that the Illinois HMO Act did relate to an ERISA plan, not only would the Act be saved as a state law regulating the business of insurance,[6/] but there is no conflict with any ERISA remedy. *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987). Under the Court's conflict analysis, a state law is only in conflict with a federal law if compliance with both laws is a physical impossibility, which is not the case here, and if the state law stands as an obstacle to the objective of Congress in its enactment of ERISA. *John Hancock Mutual Life Insurance Co. v. Harris Trust & Saving Bank*, 510 U.S. 86 (1993). Here, the state law complements the federal law by providing a process to ensure full and fair review not by providing a new remedy. Indeed, the Court has never recognized a process, including arbitration, as a remedy in and of itself. Instead, in order to accept Petitioner's argument, the Court must decide to extend its finding in *Pilot Life* that ERISA prohibits any remedy in addition to those specifically enumerated in its civil enforcement provisions under § 502(a). Petitioner would also have the Court find that ERISA prohibits any process other than that enumerated in § 503.

In any event, given the Court's recent rulings on ERISA pre-emption, *Pilot Life* should be reexamined. Its statement that ERISA's civil enforcement provisions trump Congress' intent to maintain the states' power to regulate the business of insurance as explicitly stated in ERISA's saving clause should be repudiated. First, where Congress has expressly stated its intent to carve out certain areas of the law from the federal domain, the Court need not look to the statute as whole to deduce Congress' intent; Congress has already spoken. *Cipollone*, 505 U.S. 504. Second, the Court's reliance on LMRA § 301 is misplaced in that the statute has no carve out provision similar to ERISA's saving clause. Indeed, the Court's subsequent pre-emption decisions would counsel that

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6/ *Amici* do not address whether the Illinois HMO Act is a law regulating the business of insurance under the guidelines articulated in *UNUM v. Ward*.

an explicit pre-emption would not be overcome by an implied determination of Congressional intent. *Cipollone*, 505 U.S. at 516.

For all of these reasons, the Court should affirm the Seventh Circuit's decision that ERISA does not pre-empt the Illinois HMO Act.

ARGUMENT

I. ERISA DOES NOT PRE-EMPT THE ILLINOIS HMO ACT BECAUSE IT DOES NOT RELATE TO AN ERISA PLAN.

Amici contend that Petitioner has not overcome the presumption that ERISA does not pre-empt § 4-10 of the Illinois HMO Act -- a state law regulating health care.[7/] First, the Act does not regulate ERISA plans, but service providers to ERISA plans. Second, the Act does not reference ERISA plans; plans still may choose the method by which they provide benefits to their beneficiaries. Third, the Act does not have a significant connection with an ERISA plan because it does not fall within the three types of states laws that the Court has recognized will always have a connection with an ERISA plan -- those that mandate benefit structures or plan administration, those that bind employers or plan administrators to particular choices, and those that provide alternate enforcement mechanism. Finally, there is also no significant connection with an ERISA plan because the Act does not regulate a principal ERISA relationship.

7/ The statute provides in pertinent part:

Medical Necessity - Dispute Resolution- Independent Second Opinion. Each Health Maintenance Organization shall provide a mechanism for the timely review by a physician . . . who is unaffiliated with the Health Maintenance Organization, . . .in the event of a dispute between the primary care physician and the Health Maintenance Organization regarding the medical necessity of a covered service proposed by a primary care physician. 215 ILL. COMP. STAT. § 125/4-10 (2001).

A. The Presumption Against Pre-emption Applies to the Illinois HMO Act Because It Regulates Health Care -- an Area of Traditional State Concern.

When Congress passed ERISA, it limited a State's power to regulate only to the extent that its laws relate to employee benefit plans. ERISA § 514(a), 29 U.S.C. § 1144(a).[3] In its search to better define the parameters of the "relates to" portion of ERISA's pre-emption clause, the Court has recently turned to traditional pre-emption concepts to assist in its analysis. In *Travelers*, the Court specifically adopted the *Rice* presumption that ERISA should not pre-empt state laws unless it is clear that Congress intended to do so. 514 U.S. at 654-55, quoting *Rice*, 331 U.S. at 230 (consideration of whether a federal law pre-empts state law starts with "the assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress."). "Accordingly, the purpose of Congress is the ultimate touchstone of pre-emption analysis." *Cipollone*, 505 U.S. at 516; *see* U.S. CONST. art. VI, cl. 2. *Dillingham* reaffirmed this statement in *Cipollone* by holding that there must be an "indication in ERISA . . . [or] its legislative history of any intent on the part of Congress to pre-empt" a traditionally state-regulated area of law. 519 U.S. at 331.

Dillingham held that a state law only "relates to" an ERISA plan if it refers to or has a significant connection with an ERISA plan. In order for a state law to reference an ERISA plan, the state law must act immediately and exclusively upon an ERISA plan, or the existence of an ERISA plan is essential to the law's operation. *Id.* at 325. In order to determine whether the law has a significant connection to an ERISA plan, a court must examine ERISA's objectives to determine whether the type of state law at issue is one that Congress would not have intended to pre-empt and

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[3] ERISA § 514(a) states, in pertinent part, that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan."

then analyze the effect the state law has on ERISA plans. *Id.* at 332. "[I]f ERISA were concerned with any state action--such as medical-care quality standards or hospital workplace regulations--that increased costs of providing certain benefits, and thereby potentially affected the choices made by ERISA plans, we could scarcely see the end of ERISA's pre-emptive reach." *Id.* at 329; *accord*, *Egelhoff v. Egelhoff*, 532 U.S. 141, 121 S. Ct. 1322, 1327 (2001).

The Court's more recent analysis of ERISA pre-emption cases demonstrates a conscientious application of this presumption so that state laws only relate to an employee benefit plan, and therefore are pre-empted, if they truly impact ERISA's core concerns. *Compare Egelhoff*, 121 S. Ct. 1322 (state law governing the payment of benefits is pre-empted) and *Boggs v. Boggs*, 520 U.S. 833 (1997) (state law governing entitlement to benefits is pre-empted), *with De Buono v. NYSA-ILA Medical & Clinical Services Fund*, 520 U.S. 806 (1997) (state tax on gross receipts with minimal impact on plan administration is not pre-empted), and *Dillingham*, 519 U.S. 316 (prevailing wage statute posed no requirement on ERISA plans and is not pre-empted). Because health plans were not a focus of Congress' concern during the enactment of ERISA, ABA Section of Labor and Employment Law, EMPLOYEE BENEFITS LAW lxviii-lxix (2d ed. 2000), and health issues are a traditional area of state concern, *Travelers*, 514 U.S. at 654-55, generally state health laws are not pre-empted.

ERISA's pre-emption clause simply does not reach the Illinois' HMO Act provisions at issue because the state law merely requires HMOs to obtain independent second opinions when there is a dispute between its medical necessity decisions and those of treating physicians operating within their network. The Illinois law functions to regulate health care – a traditional area of state power which Congress did not intend to limit when it enacted ERISA. *Travelers*, 514 U.S. at 654-55.

B. The Illinois HMO Act Regulates HMOs as Medical Service Providers, Not as ERISA Plans.

ERISA will pre-empt a state law only if it relates to an ERISA plan. If an ERISA plan is not involved, there can be no ERISA pre-emption. *Cf. Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987) (where there is no ongoing administration such as in a one-time severance benefit there was no "plan" and the state law was not pre-empted). Thus, as the Court has recognized, it is imperative to determine whether the entity asserting ERISA's pre-emptive shield is an ERISA plan. *See, e.g., Pegram*, 530 U.S. at 223, 227.

When an employer establishes an employee health benefits plan, there are a variety of ways it can structure the provision of those benefits to employees. Employers may implement a plan through the purchase of insurance, self-funding, and/or the use of service providers such as managed health care organizations like HMOs or preferred provider organizations (PPOs). Simply because an ERISA plan purchases the services of an HMO does not mean that the HMO becomes the ERISA plan; such a finding would allow ERISA's pre-emption provisions to insulate the HMO from all state regulation. *See Pegram*, 530 U.S. at 223, 227 (documents establishing the HMOs do not establish an ERISA plan; "the HMO is not the ERISA plan").

Consistent with this distinction as articulated in *Pegram*, *Gregoire* recognized the difference between an ERISA plan and a service provider to that plan. The court found that a state's alternative provider statute did not have a significant connection with an ERISA plan because the statute required action solely by health providers; it did not require an ERISA plan to do anything. The statute only regulated and mandated benefits provided by insurers. The "mere fact that the Act regulates a product that ERISA plans often choose to buy does not mean that it 'relates to' an ERISA plan." 147 F.3d at 1045. *See generally Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 728-29 (1985) (states may require insurers to offer mental health benefits).

Here, the state of Illinois has decided that HMOs must provide for a second opinion if the primary care physician and HMO disagree over whether a particular procedure is medically necessary. The state law does not require the ERISA plan to do anything "It is merely one of many state laws that regulates one of many products that an employee benefit plan might choose to buy." *Gregoire*, 147 F.3d at 1044-45. Indeed, this is no different than the situation in *Dillingham*. Although an ERISA plan could have been used as a vehicle for paying prevailing wages to apprentices, there was nothing in California's prevailing wage statute that required the employer to do so. Thus the Court held that ERISA did not pre-empt the state prevailing wage law. *Dillingham*, 519 U.S. at 325-28. While the Illinois HMO Act regulates Rush-Prudential as the provider of medical services, the mere fact that Rush-Prudential provides those services to the beneficiaries of an ERISA plan does not mean the HMO's Act relates to an ERISA plan. On this basis alone, ERISA does not pre-empt the Illinois HMO Act.

C. The Illinois HMO Act Has No Reference To ERISA Plans Because It Does Not Require Plans or Administrators to Use HMOs as Medical Service Providers.

In *Dillingham*, the Court held that in order for a state law to reference an ERISA plan, the state law must act immediately and exclusively upon an ERISA plan or the existence of an ERISA plan is essential to the law's operation. In *Dillingham*, the Court declined to find that the state prevailing wage law made a reference to ERISA plans. The Court based its decision on the fact that apprenticeship programs need not necessarily be ERISA plans, and the employer could pay apprentices out of its general assets. The Court found that the prevailing wage law functioned regardless of whether an ERISA plan existed. 519 U.S. at 325.

The Illinois HMO Act is no different than the prevailing wage law in *Dillingham*. The Illinois HMO Act functions only where an HMO is involved. The HMO Act functions regardless of the entity (e.g., an individual, a church plan, a governmental plan) which purchases the services of an HMO as a medical service provider. The HMO Act functions irrespective of whether an ERISA plan uses an HMO as a medical service provider. It makes no reference to ERISA plans, and is not pre-empted on that basis. *See id.* at 328.

D. The Illinois HMO Act Does Not Have A Significant Connection With ERISA Plans.

1. The Illinois HMO Act does not mandate employee benefit structures, bind employers or administrators to particular choices, preclude uniform administrative practices, or provide alternate enforcement mechanisms to obtain benefits.

In *Travelers*, the Court recognized that three types of state laws will always be pre-empted: (1) state laws that mandate employee benefit structures or their administration; (2) state laws that bind employers or plan administrators to particular choices or preclude uniform administrative practice, thereby functioning as regulations of ERISA plans themselves; and (3) state laws providing alternate enforcement mechanisms for employees to obtain ERISA plan benefits. These types of state laws are certainly within the field that Congress intended to occupy when it enacted ERISA and will always have a connection to an ERISA plan. *See Travelers*, 514 U.S. at 657-60.

Since *Travelers*, the Court has attempted to provide guidance on the types of laws that fall into these categories. State laws that interfere with ERISA's distribution of benefits scheme or a plan's administrative functions have been pre-empted. *See, e.g., Egelhoff*, 121 S. Ct. at 1327; *UNUM Life Insurance Co. of America v. Ward*, 526 U.S. 358, 378-79 (1999); *Boggs*, 520 U.S 833. In contrast, where the state statute merely alters the economic incentives involved, ERISA

does not pre-empt the state law. *See, e.g., De Buono*, 520 U.S. at 815; *Dillingham*, 519 U.S. at 334.

The Illinois HMO Act does not mandate benefit structures or their administration because it does not address who will receive benefits, the kind of benefits to be paid, or how those benefits will be paid. *Compare Egelhoff*, 121 S. Ct. 1322 (2001); *Boggs*, 520 U.S. 833 (1997); *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985).

The Illinois HMO Act does not bind the employer or the plan administrator to any particular choice concerning benefits or administrative practices. For an ERISA plan, the Illinois Act only is triggered if it employs an HMO as a provider of medical services. The plan has a choice in choosing its provider of medical services. *Dillingham*, 519 U.S. at 325. The Illinois Act does not bind the plan to any choices concerning the provision of medical provider. The Act assumes that the plan covers the medical treatment if the HMO and the primary care physician agree that the treatment is medically necessary. Instead, this statute is limited to providing a process solely for determining appropriate medical treatment, an area of traditional state concern. The Court has recently recognized that decisions concerning medical necessity are not pre-empted because they are more akin to medical treatment decisions. *See Pegram*, 530 U.S. 211 (in *dicta*, mixed benefit eligibility and treatment decisions are not pre-empted); *Travelers*, 514 U.S. at 654-55. Thus, the Illinois HMO Act does not bind the employer or plan administrator to any particular choices concerning benefits.

Moreover, nothing in this Act dictates procedures to guide processing of claims and disbursement of benefits. *Egelhoff*, 121 S. Ct. at 1328 (quoting *Fort Halifax*, 482 U.S. at 9). Unlike the statutes involved in *Egelhoff* and *Boggs*, the HMO Act has nothing to do with the disbursement of benefits. The Illinois HMO Act does not dictate the payment of plan benefits. The Illinois HMO Act neither binds employers or plan administrators to particular choices concerning benefits or precludes uniform administrative practice. However, it does bind the HMO as medical service provider. "In the

event that the reviewing physician determines the covered service to be medically necessary, the Health Maintenance organization shall provided covered service." 215 ILL. COMP. STAT. § 125/4-10 (2001). It is a matter of contract and negotiation between the HMO and the plan whether, and how, to fund the requested service, but the HMO Act does not control that relationship.

Finally, this Act does not provide an alternate enforcement mechanism for a participant to obtain ERISA benefits. Under the Act, although the participant may file a complaint with the Insurance Commissioner if the HMO is not in compliance with the Act, the statute provides only that the Commissioner may act on the complaint by investigating the HMO and taking appropriate action such as levying fines and penalties.[2/] 215 ILL. COMP. STAT. § 134/105 (2001). Under the Illinois HMO Act, the participant has no right to initiate the second opinion process, has no right to appeal a denial of benefits and has no right to obtain benefits. 215 ILL. COMP. STAT. § 125/4-10 (2001). Indeed, the statute only applies when a physician disagrees with the HMOs determination that the requested services are not medically necessary. *Cf. Corporate Health v. Texas Dep't of Ins.*, 220 F.3d 641, 644-45 (5th Cir. 2000) (where patients can appeal "adverse determination" of managed care entities as to coverage, Texas IRO provisions created an alternative enforcement mechanism). In Illinois, the participants' only option in the face of the HMO's continued refusal to provide the services is to file a benefit claim under the plan's benefit claim process and/or sue under ERISA's civil enforcement procedures. By the plain language of its terms, § 4-10 of the Illinois HMO Act does not provide an alternative enforcement mechanism.

Accordingly, unlike the state statute at issue in *Egelhoff*, the Illinois HMO Act does not "implicate[] an area of core

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[2/] Investigation by the state insurance commissioner for violation of state insurance laws is a classic insurance examination process. *E.g.*, Peter M. Lencsis, INSURANCE REGULATION IN THE UNITED STATES: AN OVERVIEW FOR BUSINESS AND GOVERNMENT 31, 106 (1997).

ERISA concern," *Egelhoff*, 121 S. Ct. at 1327, and thus does not fall into any of the three categories of state laws that the Court has recognized will always have a connection with an ERISA plan. Hence, the Act does not relate to an ERISA plan and is not pre-empted.

2. The Illinois HMO Act does not have a significant connection with ERISA plans because there is no clear manifestation of Congressional intent to pre-empt laws concerning the relationship between physicians and service providers to ERISA plans.

In *Dillingham*, the Court held that there must be an "indication in ERISA . . . [or] its legislative history of any intent on the part of Congress to pre-empt" a traditionally state-regulated area of law. 516 U.S. at 331. Health care, and particularly physician relationships involving quality of medical care, is a traditional area of state regulation. *See Pegram*, 530 U.S. at 237 (refusal to federalize medical malpractice suits); *Travelers*, 514 U.S. at 654-55.

Nothing in ERISA or its legislative history evinces a clear legislative intent to pre-empt traditional state laws that do not affect the relations among the principal ERISA entities – the employer, the plan fiduciaries, the plan, and the beneficiaries. *See, e.g., Blue Cross of California v. Anesthesia Care Associates Medical Group, Inc.*, 187 F.3d at 1054; *Arizona State Carpenters Pension Trust Fund v. Citibank*, 125 F.3d 715, 724 (9th Cir. 1997); *Custer*, 89 F.3d at 1167. When a state law does not regulate an ERISA-governed relationship, it will not be pre-empted. *See id.*; *Hospice of Metro Denver, Inc. v. Group Health Insurance of Oklahoma, Inc.*, 944 F.2d 752, 756 (10th Cir. 1991) (law affecting the relations between an ERISA entity and an outside party is not pre-empted). Quite simply, if there is no regulation of an ERISA-governed relationship, more likely than not, there will be no significant effect on the structure, administration, or the type of benefits provided by the plan. *Id.*

Here, the Illinois HMO Act regulates only the relationship between the primary care physician and the HMO. Nothing in ERISA or its legislative history indicates any intent to regulate the relationship between a medical service provider and its doctors. Indeed, the Court has refused to read any Congressional intent to regulate doctors as doctors into ERISA. *Cf. Pegram*, 530 U.S. at 237, citing *Travelers*, 514 U.S. at 654-55 (declining to turn a state cause of action for medical malpractice into an ERISA fiduciary claim).

The Court has acknowledged that a determination of medical necessity is, in part, a treatment decision, and, as such, is more closely aligned with state malpractice and quality of care claims rather than federal benefit eligibility claims. Such claims would not be pre-empted. *See Pegram*, 530 U.S. at 229, 237, citing *Travelers*, 514 U.S. at 654-55; *Bauman v. U.S. Healthcare, Inc.*, 193 F.3d 151, 162 (3d Cir. 1999), *cert. denied*, 530 U.S. 1242 (2000) ("when the HMO acts under the ERISA plan as a health care provider, it arranges and provides medical treatment, directly or though contracts with hospitals, doctors, or nurses. . . . In performing these activities, the HMO is . . . subject to the prevailing state standard of care").

The Illinois HMO Act provides procedures to resolve disputes concerning appropriate medical treatment decisions. Because the state law here concerns disputes over medical treatment decisions, not benefit eligibility, it is within the states' purview to regulate such disputes without interference from ERISA.

II. ERISA DOES NOT PRE-EMPT § 4-10 OF THE ILLINOIS HMO ACT BECAUSE THERE ARE NO IRRECONCILABLE CONFLICTS WITH ERISA.

In previous decisions, the Court has recognized the possibility of dual federal and state regulation of ERISA plans. *See, e.g., Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (states may mandate benefits in insured ERISA plans). In *John Hancock*, the Court

recognized that "ERISA leaves room for complementary or dual federal and state regulation[.]" 510 U.S. at 98. Significantly, the Court held that generally state law governing insurance is not displaced. Federal pre-emption of state insurance regulation would only occur "'where compliance with both federal and state regulations is a physical impossibility,'" *Boggs*, 520 U.S. at 844 (quoting *Gade v. National Solid Wastes Management Ass'n*, 505 U.S. 88, 98 (1992)), or "'where [that] law stands as an obstacle to the accomplishment of the full purposes and objectives of Congress[.]'" *John Hancock*, 510 U.S. at 99 (first alteration in original) (quoting *Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238, 248 (1984)). In *John Hancock*, the Court "call[ed] for federal supremacy [only] when the two regimes cannot be harmonized or accommodated." *Id.* at 98. In essence, the Court construed ERISA to set minimum standards which insurance laws can complement or supplement.

Analysis of recent ERISA pre-emption case law shows that compliance with the requirements of both the Illinois HMO Act and ERISA can be harmonized or accommodated. Here, compliance with both laws is physically possible and the HMO Act does not stand as an obstacle to the accomplishment of the full purposes and objectives of Congress. We address each prong of this analysis.

A. A Plan Can Comply with Both the Illinois HMO Act And ERISA Because There Are No Irreconcilable Conflicts.

Recent cases illustrate the high burden which must be met in order for the Court to find that compliance with both federal and state laws is a physical impossibility. In *John Hancock*, the Court rejected the argument that ERISA and state insurance laws were at odds and "would pose irreconcilable conflicts between state and federal regulatory schemes" concerning the regulation of insurance general account contracts. 510 U.S. at 97. The Court did not find that ERISA's fiduciary requirement to act solely in the interest of participants and state insurance requirements to consider the interests of all its contract holders, creditors and

shareholders were in conflict, but rather these requirements could exist as dual federal and state regulation. *Id.* at 97-98.

Subsequently, in *UNUM v. Ward*, 526 U.S. at 374-77, the Court rejected UNUM's argument that California's notice-prejudice rule conflicts with the substantive provisions of ERISA. The Court held that states have the power to alter the terms of the insurance relationship because to hold otherwise would read the saving clause out of ERISA and create a unintended conflict with ERISA's fiduciary requirement of acting in accordance with the plan documents. The Court's reasoning in *UNUM* is also valid in this case. In *UNUM*, the Court summarily rejected the argument that there is a conflict with the civil enforcement provisions since, as in this case, Mr. Ward had to sue under § 502(a) in order to recover his benefits. Finally, the Court held that the state law, by allowing a longer period to file rather than ERISA's minimum time, complemented ERISA. Here, the Illinois HMO Act merely provides full and fair review in the administrative hearing process.

Indeed, all the Illinois HMO Act does is to provide a constructive mechanism to manage disputes over medical treatment between physicians and the HMOs with which they are affiliated. If an insured disagrees with a determination of medical necessity of either the treating physician or the HMO or the HMO decides not to follow the second opinion, as in this case, the insured's only recourse in the face of a continued denial is to follow the ERISA claim procedures, and if necessary, file suit under ERISA § 502(a), 29 U.S.C. § 1132(a). The Illinois HMO Act complements ERISA's enforcement scheme. It does not provide any additional remedies beyond those which ERISA provides.

Because an HMO can physically comply with both the Illinois' HMO Act and ERISA, there is no irreconcilable conflict between these two laws.

B. The Illinois HMO Act Does Not Stand as an Obstacle to The Accomplishment and Execution of the Full Purposes and Objectives of Congress in its Enactment of ERISA.

The "stands as an obstacle" prong for determining whether there is a conflict between state and federal law requires the Court to determine the intent of Congress and the determination whether Congress intended to occupy the field. Paul Wolfson, *Pre-emption and Federalism: The Missing Link*, 16 HASTINGS CONST. L.Q. 69 (1988). Because Congress specifically ceded power back to the states to regulate the business of insurance in § 514(b), the entity arguing that there is a conflict between ERISA and state insurance law has a high burden to show the state insurance law cannot be harmonized and accommodated with ERISA. *John Hancock*, 510 U.S. at 97-98.

> Analysis of whether a state law frustrates the attainment of Congress' objectives involves several steps: an identification of congressional purposes; an assessment of the effect of the state law; and a determination whether that effect "stands as an obstacle" to one of the purposes underlying the federal law.

Karen A. Jordan, *The Shifting Pre-emption Paradigm: Conceptual and Interpretive Issues*, 51 VAND. L. REV. 1149, 1200 (1998).

ERISA's declared principal purpose is "to protect plan participants and beneficiaries." *Boggs*, 520 U.S. at 845 (citing *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983)); ERISA § 2(b), 29 U.S.C. § 1001(b). Among the ways participants and beneficiaries are to be protected is by providing for "appropriate remedies, sanctions and ready access to Federal courts." ERISA § 2(b), 29 U.S.C. § 1001(b). In this instance, as in *UNUM v. Ward*, state insurance laws may set standards in addition to ERISA's minimum standards so as to better protect insureds. Merely because federal and state laws are different does not mean that

there is an impermissible conflict. ERISA is not absolute, but explicitly recognizes a role for state insurance regulation, thus permitting state insurance laws to supplement or complement ERISA's standards. *John Hancock*, 510 U.S. at 97-98; *cf. Wisconsin Public Intervenor v. Mortier*, 501 U.S. 597 (1991) (federal law set the minimum standard for pesticide use, and thus did not pre-empt local rules); *Florida Lime & Avocado Growers, Inc. v. Paul*, 373 U.S. 132 (1963) (federal law did not pre-empt state law setting other standards for measuring the maturity of avocados).

This analysis is consistent with the Court's decisions in *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), and *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985). In *Metropolitan Life Insurance*, the Court held that ERISA did not pre-empt a state law mandating minimum mental health benefits because it was exempted under the saving clause. *Id.* at 744. The Court did not find that state laws regulating the substantive terms of group health insurance contracts conflict with ERISA. Similarly, in *FMC Corp.*, the Court held that a state anti-subrogation clause was pre-empted as applied to a self-funded ERISA plan. The Court emphatically stated:

> [I]f a plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer's insurance contracts; if the plan is uninsured, the State may not regulate it. As a result, employers will not face "conflicting or inconsistent State and local regulation of employee benefit plans."

FMC Corp., 498 U.S. at 64 (quoting *Shaw*, 463 U.S. at 99). Thus, the Court implicitly found that state insurance regulation did not lead to conflict or inconsistency with ERISA.

Petitioner analogizes the Illinois HMO Act to arbitration. This analogy fails for two reasons. First, insureds have no right to initiate the non-binding second opinion process; clearly this is contrary to binding arbitration. Second, even

if the process is binding, insureds do not obtain the remedy they are seeking -- their benefits.

When the Court has discussed "remedies," and whether ERISA provides for certain remedies, it has done so using the common sense meaning of the word. Thus, the Court has defined remedies as injunctions, payment of money, writs of mandamus, damages, specific performance, restitution, and extra contractual remedies. *See generally Harris Trust & Savings Bank v. Salomon Smith Barney Inc.*, 530 U.S. 238 (2000) (permitting restitution); *Mertens v. Hewitt Associates*, 508 U.S. 248, 256-58 (1993) (equitable relief); *Massachusetts Mutual Life Insurance Co. v. Russell*, 473 U.S. 134, 144 (1985) (extra contractual damages).

Not surprisingly, the Court has never mentioned or considered non-binding arbitration as a remedy, in and of itself. Instead, it is a process or procedure to obtain a remedy, such as money or reinstatement. Even in binding arbitration, in order to enforce the arbitral award and obtain back pay for example, the winning party may still have to go to court under the relevant statute. *See, e.g., United Steelworkers v. Enterprise Wheel & Car Corp.*, 363 U.S. 593 (1960); *United Steelworkers v. Warrior & Gulf Navigation Co.*, 363 U.S. 574 (1960); *United Steelworkers v. American Manufacturing Co.*, 363 U.S. 564 (1960). Thus, Petitioner's analogy between § 4-10 of the Illinois HMO Act and arbitration is instructive because like arbitration, in order to obtain the available remedy -- benefits, the participant must still sue under ERISA's civil enforcement provisions. It is not the process or the procedure, which is the remedy - it is the benefit which is the remedy.

Petitioner's real complaint is that § 4-10 of the Illinois HMO Act may have some impact on the ultimate result in the benefits claims process. In a lawsuit under ERISA § 502(a)(1)(B) - the insureds' only method of obtaining their benefits - it is probable that a court will look at the second reviewer's decision in determining whether the plan properly withheld benefits under the appropriate standard of review. *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101

(1989). Thus, for example, if the plan refuses to provide the benefit to the participant after the second opinion, and the participant sues for benefits, the plan's denial of benefits might be reviewed under the arbitrary and capricious standard. Petitioner may anticipate that it will be harder to prove that its actions were not arbitrary and capricious in its denial of the claim where both the primary care physician and an independent second opinion disagree with the HMO's decision. Indeed, the converse would also be true – it would be harder for the participant to show an abuse of discretion if the independent reviewer agrees with the HMO. In either event, such impact on the standard of review does not make the Illinois HMO Act a new remedy.

In essence, Petitioner espouses that ERISA's claims procedure under § 503 is exclusive of all other review procedures. Petitioner's analogy here to *Pilot Life*'s finding that the civil enforcement provisions of § 502(a) are exclusive fails. Because the Illinois HMO Act is consistent with ERISA's requirement of providing full and fair review under § 503, there is no conflict. Indeed, as in *John Hancock* and *UNUM*, the state law can be harmonized with ERISA. *See UNUM v. Ward*, 526 U.S. at 377; *John Hancock*, 510 U.S. at 97-98.

Under the Illinois statute, participants still have to file a benefits claim and file a lawsuit under ERISA's civil enforcement provisions if their benefits claim is denied. There is no conflict or inconsistency with ERISA. The Illinois HMO Act cannot be found to stand as an obstacle to the accomplishment and execution of Congressional purposes and objectives. Instead, this law can easily be harmonized or accommodated with ERISA and should not be pre-empted.

III. BECAUSE CONGRESS EXPRESSLY INDICATED ITS INTENT THAT STATE LAWS REGULATING INSURANCE ARE OUTSIDE THE FIELD OF ERISA PRE-EMPTION, *PILOT LIFE* INCORRECTLY FOUND THAT THE SCOPE OF ERISA'S SAVING CLAUSE WAS LIMITED BY REFERENCE TO ERISA'S CIVIL ENFORCEMENT MECHANISMS.

When Congress enacted ERISA's pre-emption clause, it expressly demarcated which laws would not be pre-empted. Congress explicitly and clearly stated that states would retain the power to regulate insurance even where state insurance laws applied to employee benefit plans.[10/] ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A).[11/] Significantly, the Court has recognized Congress' intent to circumscribe the field of ERISA pre-emption by ceding power back to the states to regulate insurers and has interpreted this provision to give effect to this intent. *See, e.g., UNUM v. Ward*, 526 U.S. 358; *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. at 728-29.

The Court has recognized that field pre-emption may be found if state law regulates conduct in a field that Congress intended the federal government to occupy exclusively. Such intent may be inferred from a scheme of federal regulation so pervasive that Congress left no room for states to supplement it or where the act of Congress touches a field where the federal law is so dominant that the federal system will be assumed to preclude enforcement of state laws on the same subject. However, Congress' intent to do so must be clear

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10/ Although deciphering Congressional intent in ERISA's relate to clause may be difficult because the language of that clause is unhelpful, *see Travelers*, 514 U.S. at 656, the one clause in which Congressional intent is clearly stated is in the saving clause.

11/ ERISA § 514(b)(2)(A) states, in pertinent part, that: "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any States which regulates insurance . . . "

and manifest. *See Cipollone*, 505 U.S. at 516.

In *Cipollone,* the Court addressed the issue of the interrelationship between an express pre-emption clause, like the one at issue here, and implied field pre-emption. It held that:

> When Congress has considered the issue of pre-emption and has included in the enacted legislation a provision explicitly addressing that issue, and when that provision provides a "reliable indicium of congressional intent with respect to state authority," "there is no need to infer congressional intent to pre-empt state laws from the substantive provisions" of the legislation.

Cipollone, 505 U.S. at 517 (citations omitted). Accordingly, where Congress has enacted a provision expressly authorizing the states to retain their power to regulate in certain areas of law, it unequivocally establishes that such matters are not pre-empted. *Id.*

Contrary to these principles in *Cipollone*, the decision in *Pilot Life*, 481 U.S. at 52, ignored the saving clause, which showed Congress' manifest intent to maintain the states' authority to regulate the business of insurance. Instead, the Court looked at legislative history declaring that the pre-emptive force of ERISA § 502(a) was modeled on the exclusive remedy provided by the Labor Management Relations Act § 301, 29 U.S.C. § 185 (2001) ("LMRA"), and the language and structure of the civil enforcement provisions. It concluded that Congress intended that the civil enforcement provisions of ERISA § 502(a) were to be the exclusive vehicles for actions by insureds alleging improper processing of benefit claims. Accordingly, even if the state law was saved from pre-emption as a law regulating insurance, the Court would have found that the state law would still be pre-empted because it provided for remedies that ERISA does not provide. *Pilot Life*, 481 U.S. at 55.

Because ERISA's saving clause is explicit and there is no question of Congress' intent to permit the states to regulate the business of insurance, there was no need for the Court to look at anything but the plain language of the statute. It was unnecessary for the Court to continue its analysis. Moreover, not only do later cases call into question the underpinnings of the Court's decision, but the Court's conclusion does a disservice to the statute by not giving effect to Congress' intent.

In addition, even if the Court believed that it needed to further discern Congressional intent, the rationale of its decision missed the mark. Unlike ERISA, the Labor Management Relations Act does not have an express pre-emption clause, let alone a specific clause carving out certain areas of the law which are not pre-empted. Instead, the Court has implied field pre-emption from LMRA § 301 where the state law claim relies upon the analysis of the terms of the collective bargaining agreement. *See Allis-Chalmers Corp. v. Lueck*, 471 U.S. 202, 220 (1985). In discussing the pre-emptive force of § 301, the Court has found that Congress intended doctrines of federal labor law to prevail over inconsistent state rules. *See Teamsters v. Lucas Flour Co.*, 369 U.S. 95, 103-04 (1962). Indeed, finding that the enforcement mechanism of § 301 is exclusive is wholly consistent with field pre-emption principles – federal regulation of an area of law that is so pervasive that Congress left no room for states to supplement.

Assuming that a comparison between ERISA § 514(a) (ERISA's "relates to" clause) and LMRA § 301 is, in some sense, appropriate, as to the general scope of pre-emption, such comparison gives no guidance here because LMRA § 301 does not have a saving clause similar to ERISA § 514(b)(2)(A). Unlike the Congressional intent to cede power to the states to legislate in the business of insurance emphatically shown in ERISA's saving clause, the Court has never found Congressional intent to permit states to supplement federal power in the field of labor relations.

In *Franchise Tax Board of California v. Construction*

Laborers Vacation Trust Fund for Southern California, 463 U.S. 1 (1983), the Court explicitly recognized the difference between ERISA § 514 and LMRA § 301. The Court stated that "[Section 502(a)] does not purport to reach every question relating to plans covered by ERISA. Furthermore, § 514(b)(2)(A) of ERISA, 29 U.S.C. § 1144(b)(2)(A), makes clear that Congress did not intend to pre-empt entirely every state cause of action relating to such plans." *Id.* at 25. "In contrast, § 301(a) of the LMRA applies to all '[suits] for violations of contracts between an employer and a labor organization. . . .'" *Id.* at 25 n.28. The Court recognized that ERISA expressly permits states to regulate ERISA plans through certain mechanisms and thereby supplement federal law, while the LMRA has no such method for states to supplement federal law.

Section 514(b)(2)(A) of ERISA helps to define the field of ERISA pre-emption - state regulation of insurance is not within that field. Congress specifically permitted states to directly regulate the business of insurance and indirectly regulate ERISA plans that purchase services from insurers. Because ERISA's field of state laws that may be pre-empted does not include those regulating the business of insurance, ERISA's civil enforcement provisions are not the exclusive means of enforcement when it comes to insurers. As long as there is no direct conflict with ERISA, as *amici* have already demonstrated, the Illinois HMO law may act as a supplement to federal law. *See UNUM v. Ward*, 526 U.S. at 377; *John Hancock*, 510 U.S. at 98 (dual state and federal regulation of ERISA plans is permitted).

Not surprisingly then, the Court has found that state mandated benefits statutes imposing requirements on insurers as well as procedures for filing claims with insurers are saved from ERISA pre-emption. *See UNUM v. Ward*, 526 U.S. at 373-75 (1999); *Metropolitan Life Insurance Co. v. Massachusetts,* 471 U.S. at 742-45. Although the Court recognized that such an interpretation would result in "disuniformities currently facing national plans" entering local insurance markets, such disuniformities "are the inevitable result of the congressional decision to 'save' local insurance

regulation." *See id.* at 747.

In *Pilot Life*, the Court also relied on the totality of ERISA's structure and language to support its finding that ERISA's civil enforcement provisions are exclusive. This finding is in conflict with the Court's more recent ERISA rulings. As the Court has recognized repeatedly, "[a]s in any case of statutory construction, our analysis begins with the language of the statute . . . And where the statutory language provides a clear answer, it ends there as well." *See Harris Trust & Savings v. Salomon Smith Barney, Inc.*, 530 U.S. 238, 254 (2000) (quoting *Hughes Aircraft Co. v. Jacobson*, 525 U.S. 432, 438 (1999)). The Court's interpretation of ERISA's pre-emption clause in *Pilot Life* departs from the statutory text. Indeed, if ERISA is as "comprehensive and reticulated" as the Court has stated, *id.* at 2187, Congress could have easily stated that the civil enforcement provisions are exclusive. *See Inter-Modal Rail Employees Ass'n v. Atchison, Topeka & Santa Fe Railway Co.*, 520 U.S. 510, 515 (1997) ("Had Congress intended . . . it could have easily" done so.) It did not.

Instead, reliance on the structure and language of ERISA should have led the Court in *Pilot Life* to a conclusion the opposite of the one it drew. *Cipollone* would counsel that it would be rare for other provisions of a federal law to overcome an explicit pre-emption provision. 505 U.S. at 516, Significantly, the Court ignored the established rule that a statute, if possible, should be construed in such a fashion that every word or, in this case, every section has some operative effect so that no part will be rendered superfluous. *Mertens*, 508 U.S. at 257-58 (citing *United States v. Nordic Village, Inc.*, 503 U.S. 30, 36 (1992); *Moskal v. United States*, 498 U.S. 103, 109-10 (1990)). Its analysis in *Pilot Life* of the relationship between the civil enforcement provisions and saving clause ignores explicit Congressional intent and renders the saving clause, at least in some instances, superfluous.

Quite simply, the language and structure of ERISA applies to employee benefit plans, not HMOs as insurers. The balance struck in ERISA was to protect pension plans and

their financial integrity to ensure that plan participants received the benefits they were promised. It was not to allow insurers to escape state regulation and oversight. The inference that Congress, by its scheme of limited remedies, meant those remedies to be exclusive must give way to the express and unambiguous statutory language in the saving clause that states have the right to provide insureds with a broad range of remedies against insurers. Even if § 4-10 of the Illinois HMO Act is considered an additional remedy or civil enforcement provision, it should be saved as a state law regulating the business of insurance and therefore not pre-empted.

CONCLUSION

For the above reasons, *amici* urge the Court to affirm the Seventh Circuit's decision that ERISA does not pre-empt § 4-10 of the Illinois Health Maintenance Organization Act.

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